BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A FOLLOW-UP STUDY OF 120 PATIENTS TREATED AT SOUTHARD CLINIC

A Thesis

Submitted by

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Chapter I

Introduction

The study recorded in this thesis was undertaken in an effort to determine the results of psychiatric treatment in an out-patient clinic, to gain some understanding as to why patients terminate treatment, and finally to ascertain whether follow-up by the social service department would have been a sustaining factor in continued treatment of these patients.

A. Explanation of the Study.

An analysis was made of all patients visiting Southard Clinic of Boston Psychopathic Hospital in November, 1945. This month was chosen as one relatively free from such interruptions as holidays and vacations, both from the point of view of the patients and of the clinic personnel. Since the writer was interested in studying cases that had discontinued treatment for at least six months, the year 1945 was decided on as providing enough time to demonstrate this. Eliminated from the study were patients who made one or two visits for diagnostic purposes, and those still under care and known. A total of 548 visits had been made in November, 1945, by 344 patients. Of these patients, sixteen had been referred for admission to state institutions, ninety-six had been seen for diagnostic purposes, and ninety-three were still active. Of the remain-

Chapter I

Introduction

ing 139 cases, nineteen had terminated treatment at the suggestion of the psychiatrist, and 120 had discontinued coming of their own choice and had not been seen in the clinic for at least six months.

The case study method was used. In addition to data obtained from the clinic records, form letters were sent to the 120 patients who had voluntarily discontinued treatment as a basis for determining the results of the study. Two cases were selected for intensive study to illustrate in more detail points brought out by the analysis of the data, one of the patients having had a successful experience and one having felt some dissatisfaction with psychiatric treatment in a clinic setting. The first case chosen seems fairly representative of those answering the questionnaire, in that the patient responded well to psychiatric treatment, felt that should there be a recurrence of symptoms she would return to the clinic, had terminated treatment of her own volition, and felt that she would have returned had she been urged to do so. One case showing negative response is presented, even though this group is in the minority as the study will show. Inasmuch as negative criticism was invited from the patients sent the form letter the writer felt that it would not be inappropriate to illustrate negative findings as they appeared in this case.

The patients were classified according to age, sex,

diagnosis, source of referral, and social service department contact. Similar classifications were made of those replying to the form letter.

B. Origin and Development of Southard Clinic.

The out-patient clinic of a psychiatric hospital is one of the major developments in American psychiatry that symbolizes the practice of psychiatric care beyond the confines of the asylum or mental hospital.

> The function of a modern psychiatric hospital may be briefly described as follows: It is usually located in large towns or cities. It provides first care, examination and observation for persons suffering from mental disorder, pending commitment to a general hospital. It administers short, intensive treatment in incipient and acute cases. It provides educational facilities for medical students. It functions as a center for clinical and pathological research in nervous and mental disorders. It serves as a clearing house which sorts out those persons whose mental aberrations are not of such a kind or degree as to render them socially inadequate from those whose disorder requires commitment to a mental hospital.[1]

There are four major types of psychopathic hospitals: (1) those connected with a university; (2) those connected with a general hospital; (3) those connected with a hospital for mental diseases; and (4) those which operate independently.

The first psychopathic hospital connected with a state hospital for mental diseases was opened in Boston in 1912.

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1 Albert Deutch, The Mentally Ill in America, p. 291.

> As early as 1899 Dr. Owen Copp, executive secretary of the Massachusetts State Board of Insanity, had urged the establishment of a psychopathic hospital in a special report. The agitation was continued throughout the first decade of the century by that energetic crusader for progressive lunacy legislation, Dr. L. Vernon Briggs. In 1909 the state legislature enacted a statute appropriating $600,000 for the establishment in Boston of a hospital for the 'first care and observation of mental patients, the treatment of acute and curable mental diseases and for an out patient department, treatment rooms and laboratories for scientific research as to the nature, causes and result of insanity'. The psychopathic hospital was opened in June 1912, as a department of the Boston State Hospital, which had been transferred from city to state control four years earlier. Dr. E. E. Southard, one of the foremost psychiatric researchers in the United States, was chosen as first director, a position he retained until his death in 1920. [2]

In that same year the Psychopathic Hospital was administratively separated from the Boston State Hospital, and since then has functioned as an independent unit.

The State Board of Insanity of Massachusetts in its report for 1910 outlined the functions of a model psychopathic hospital.

> The psychopathic hospital should receive all classes of mental patients for first care, examination and observation, and provide short, intensive treatment for incipient, acute and curable insanity. Its capacity shall be small, not exceeding such requirement.
>
> An adequate staff of physicians, investigators and trained workers in every department should maintain as high a standard of efficiency as that of the best general and special hospitals, or that in any field of medical science.

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2 Deutch, op. cit., p. 295.

> Ample facilities should be available for the treatment of mental and nervous conditions, the clinical study of patients in the wards, and the scientific investigation in well equipped laboratories, with a view to prevention and cure of mental diseases and an addition to the knowledge of insanity and associated problems.
>
> Clinical instruction should be given to medical students, the future family physicians, who would thus be taught to recognize and treat mental disease in its early stages, when curative measures avail most. Such a hospital, therefore, should be accessible to medical schools, other hospitals, clinics, and laboratories.
>
> It should be a center of education and training of physicians, nurses, investigators, and special workers in this and allied fields of work.
>
> Its out patient department should afford free consultation to the poor, and such advice and medical treatment as would, with the aid of district nursing, promote the home care of mental patients. Its social workers should facilitate early discharge and after care of patients, investigate their previous history, habits, home and working conditions and environment, heredity and other causes of insanity, and endeavor to apply corrective and preventive measures.[3]

This last paragraph points up an important development in psychiatric history, as well as forms the basis for the present Southard Clinic. Although the Psychopathic Hospital, at that time a department of the Boston State Hospital, was scheduled to open on June 24, 1912, a chief medical officer to have charge of the out-patient clinic was not appointed until January 1, 1913.

In reporting the activities of the first ten months of the out-patient clinic Dr. Southard states:

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3 Commonwealth of Massachusetts, Annual Report of the State Board of Insanity, 1910, pp. 29-30.

> The out patient department has been especially successful, although not yet formally opened. Social agencies of various descriptions, those dealing with children and adolescents have hastened to send their problems to the psychopathic hospital. ... There can be no doubt that the work of the out patient department, upon the diagnosis of various grades, especially of the higher grades of imbecility, upon juvenile court problems, upon sex problems with adolescents, upon incipient cases of insanity, upon speech disorders, and most important of all, upon after care and prophylactic work in connection with house cases, amply justified its existence. [4]

The total number of cases seen during the first year of existence of the out-patient department was 830, of which 223 were children.

The work of the out-patient department at this time fell roughly into four groups:

1. Those dealing with questions of feeblemindedness and mental defect, in particular those mental defects referred by courts, reformatories and other institutions, including an increasing number of backward children from schools.

2. The psychiatric cases, discharged patients from the psychopathic hospital as well as from other state hospitals. Also there is a certain number of patients who have never been in a hospital, but still require treatment for mild or incipient mental troubles of a non-committable nature.

3. Somatic cases or those requiring treatment in connection with diseases of the nervous system, the largest group being neurosyphilitics.

4. There is a group of cases that are, more narrowly speaking, cases of the social service group, requiring aid chiefly from the community's point of view. We here deal with cases suffering from the effects, pre-eminently, of poor housing, poverty, desertion, and the like, all of which evils are based upon or laid down upon the back-

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4 L. Vernon Briggs et al., History of Boston Psychopathic Hospital, p. 154.

ground of mental inadequacy. [5]

In 1916 Dr. Southard stressed the greater need for specialized social service workers, and felt that their number should be seven instead of two.

The gradual evolution of the type of patient coming to the out-patient department and the greater emphasis on earlier diagnosis, treatment and prophylaxis, is evidenced in this report of 1935:

> Not every nervous or mental patient is sick enough to be required to give up life at home and work and be admitted to a hospital for intensive study and treatment. There are those who can be quite adequately studied and treated under conditions offered by an out-patient department.[6]

A year later the same medical director, Dr. Macfie Campbell, stated:

> An out patient department with its facilities easily available fosters in the community a wholesome attitude towards the whole problem of mental disorders and tends to break down the traditional rigid separation between mental patients and all other members of the community. Whether a patient comes into the hospital or whether he gets advice in the out patient department is to a certain extent a matter of detail, and there are no different principles valid for the one group which are not valid for the other. With the out-patient as with the house patient, the consultation indicates that the handicap of the patient requires something more than the ordinary procedure which is available in the general medical or surgical service. It indicates that in addition to a review of the bodily system a review must be made of the personality of the indi-

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5 L. Vernon Briggs et al., op. cit., pp. 156-7.

6 Commonwealth of Massachusetts, Annual Report of the Trustees of the Boston Psychopathic Hospital for the Year Ending November, 1935.

> vidual and of the life situation... The out patient department, therefore, is an extremely valuable liason between the hospital and the community; it reaches out perhaps even more intimately into the life of the community; it works in close contact with teachers, with parents and with all those social agencies which have and deal with handicapped individuals.[7]

In 1943, shortly after Dr. H. C. Solomon, the present medical director, became administrator, the out-patient department was changed to its present name, Southard Clinic. The services of the clinic for teaching and practice were made available to the house doctors and medical students, with regular rotation services for both. The clinic was expanded from a morning clinic to include an afternoon session, and a full time physician devoting all his time and effort to the clinic, was appointed. Other changes at this time included a special clinic to study and treat convulsive disorders, especially epilepsy.

As a result of these changes the service of the clinic to the community was greatly increased, and the total number of visits made by patients to the Southard Clinic in 1945 was 6, 443.

C. A Brief Outline of the Organization of Southard Clinic.

The Southard Clinic is located on the ground floor of a wing of the main building of the Boston Psychopathic Hospital, with a separate entrance. The waiting room is a pleasant place; pictures, magazines, flowers, a child's

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7 Commonwealth of Massachusetts, Annual Report of the Trustees of the Boston Psychopathic Hospital for the Year Ending November, 1936.

table and chairs and toys, add to the general atmosphere of informality. The comfortable benches are arranged in an interesting fashion, so that the effect is quite unlike that of a clinic.

It operates daily from nine o'clock to five, and on Saturdays until noon. Patients are seen by appointments made usually one or two weeks in advance, although emergency appointments can be arranged. Interviews for the psychiatrists are scheduled at hourly intervals.

The clinic is administered by the medical director on a half time schedule, with one co-director serving full time and the other half time. At present one psychiatrist serves full time and another volunteers on a half time basis. Fifteen other psychiatrists serve approximately 147 clinic hours per week. In addition, the Harvard teaching unit has four psychiatrists who serve a total of twenty-four hours a week. Two psychologists are maintained by the clinic. A clinic secretary devotes all of her time to clinic work and consults regularly with the medical director and the chief social worker.

The regular and student workers of the social service staff carry both house and clinic patients, depending on the social work needs. They rotate in giving service in the clinic. All appointments are made through the clinic secretary. Appointments for children are cleared through

the part-time co-director who, after psychological studies have been made, assigns them for further psychiatric care or decides on their disposition.

On arrival at the clinic the new patient presents himself to the clinic secretary, who introduces him to the social worker assigned to clinic work for the day. The social worker takes the history, usually from the member of the family accompanying the patient. If the patient comes alone, the social history is taken with a brief notation of the presenting problem. Patients thus interviewed are automatically the responsibility of the social worker taking the history, should some social needs develop at any time. This same worker also serves as a liason person between any outside agency and the clinic in regard to the particular patient. In this way each new patient comes to the attention of some member of the social service department. The history taking interview gives the social worker the opportunity to explain clinic services and to give reassurance to the timid patient or worried relative. Moreover it provides a splendid opportunity for making a preliminary diagnosis of social needs, which is frequently the beginning of continued social case work with the patient or with the relative who accompanies him.

The only restriction to intake is in relation to feebleminded children. All other patients are accepted

regardless of age or problem. The clinic charges no fee, and the economic situation of the patient is not considered as a selective factor.

Chapter II

A Study of One Hundred and Twenty Cases Who Discontinued Treatment

The main purpose of this study was to determine some of the reasons why patients treated in an out-patient psychiatric clinic discontinue treatment, and to determine, if possible, whether some form of follow-up by the social service department would have been effective in maintaining them in treatment.

One hundred and twenty cases who had discontinued treatment and formed the basis of this study, represented 35 per cent of all the patients seen in the clinic during the month of November, 1945. The total number of patients seen during that month was 344, and they made a total of 548 visits. Of this number of patients sixteen or 5 per cent were referred to state institutions, and ninety-six or 28 per cent were seen for diagnostic purposes. Of the 232 Patients requiring treatment, ninety-three or 27 per cent are still active or known to the clinic, and nineteen or 5 per cent discontinued treatment at the suggestion of the psychiatrist. The remaining 120 who voluntarily discontinued treatment, therefore, comprise 35 per cent of the group remaining in the community who require treatment. (See Table I, page 13)

Table I

STATUS OF PATIENTS SEEN IN NOVEMBER, 1945

Status	Number	Per Cent
Referred for admission to state institutions	16	5
Seen for diagnostic reasons	96	28
Still active in the clinic	93	27
Terminated treatment by direction of psychiatrist	19	5
Voluntarily discontinued treatment	120	35
Total	344	100

This group of 120 cases who had discontinued treatment was analyzed as to distribution according to age and sex, diagnosis, source of referral, and the service received from the social service department.

Twenty of these patients or 17 per cent were between the ages of ten and thirteen, twelve or 10 per cent were in the fourteen to eighteen age group, and eighty-eight or 73 per cent were over nineteen. Of the total of 120, forty-five were males and seventy-five females. (See Table II, page 14)

In classifying the cases according to diagnosis it was found that there were thirteen children or 11 per cent who had failed to adjust in school. Five of this group were found to have difficulty in reading and were referred to the special department of the clinic that offers this

service for intensive help in this area. The others were primary behavior problems, manifested in general nervousness, or inability to focus attention in the class room.

Table II

DISTRIBUTION OF 120 CASES ACCORDING TO AGE AND SEX

Age	Sex		Number	Per Cent
	Male	Female		
10 - 13	11	9	20	17
14 - 18	5	7	12	10
19 -	29	59	88	73
Total	45	75	120	100

Nine children or 7 per cent of the group, exhibited multiple neurotic traits. One was a very seclusive child, both in school and at home. The majority of this group had made poor adjustments at home with their friends as well as in school.

The largest group, twenty-four patients or 20 per cent, were classified as suffering from depression. This diagnosis included simple depression, reactive depression, and depression with suicidal intent. Twenty-three persons or 19 per cent presented varying degrees of anxiety symptoms. Eleven persons or 9 per cent were treated for epilepsy and the case records reveal that their convulsive seizures were controlled. Schizophrenic trends were manifest in seven persons or 6 percent of the group. Twenty-four were diagnosed as mixed types of psychoneurosis, or

20 per cent. This category included persons with such disorders as compulsive thoughts, hysteria and anxiety, obsessive compulsions, neurosis, and those who presented physical complaints with no organic basis. Ten persons with psychopathic trends or 8 per cent, included those whose neurosis was severe, who were prepsychotic, or who evidenced paranoid trends. One patient in this group was a child of eight whose disorganized behavior gradually regressed until finally he was recommended for commitment to a state institution.

Table III

DISTRIBUTION OF 120 CASES ACCORDING TO DIAGNOSIS

Diagnosis	Number	Per Cent
Failure in school adjustment	13	11
Multiple neurotic traits	9	7
Anxiety	22	19
Depression	24	20
Epilepsy	11	9
Schizophrenic trends	7	6
Psychoneurosis, mixed types	24	20
Psychopathic trends	10	8
Total	120	100

This data was further analyzed as to source of referral. It was determined that thirty-seven persons or 31 per cent were referred to the clinic by hospitals not equipped with psychiatric out-patient service. The second largest number, thirty-one or 26 per cent, came of their own accord

or were referred by their families; included also were two who were referred by friends. Many factors may help to account for this. It may well be that patients wait to come for psychiatric treatment until the symptoms are self evident, or are recognizable by a layman. A more probable reason is that psychiatric services of all kinds have been popularized in the press, radio, movies, and magazines. Freer discussion and better understanding have perhaps released wider acceptance of both psychiatric diagnoses and treatment. No doubt some patients in this group had been directed to the clinic by social or health agencies without a formal referral having been made. Physicians referred twenty-three or 19 per cent of the group. Seven children or 6 per cent of the group had been referred by schools. These were children whose major asocial behavior had been evidenced in the classroom. Family agencies were responsible for referring six persons or 5 per cent, and the remaining sixteen persons or 13 per cent were referred by other social agencies. Of this last group five were referred by the American Epilepsy League, one by the court, and the others by various types of welfare agencies. (See Table IV, page 17)

Inasmuch as one of the purposes of the study was to determine whether follow-up by the social service department would have resulted in keeping these patients under treat-

ment, an analysis was made of the distribution and type of service offered this group by that department. Ninety

Table IV

DISTRIBUTION OF 120 CASES ACCORDING TO SOURCE OF REFERRAL

Source	Number	Per Cent
Hospitals	37	31
Self and family	31	26
Physicians	23	19
Schools	7	6
Family agencies	6	5
Other agencies	16	13
Total	120	100

persons or 75 per cent of the group, had no contact with the social service department beyond the initial history taking interview. Eighteen persons or 15 per cent had had some type of incidental service. In this category were included such services as interpretation of state institutional care to members of the family where it had been recommended by the psychiatrist, some help in arranging for commitment, referral to another agency for financial assistance, and vocational guidance or housekeeping service. Patients in this group were seen by the social worker two or three times. Those patients who had sustained help from the social worker numbered twelve, or 10 per cent of the group. (See Table V, page 18)

A form letter was sent to the 120 persons who had

Table IV

DISTRIBUTION OF 150 CASES ACCORDING TO

SOURCE OF REFERRAL

Source	Number	Per Cent
Hospitals	37	21
Self and Family	31	20
Physicians	23	15
Schools	7	5
Family agencies	6	3
Other agencies	18	13
Total	150	100

discontinued treatment (see appendix). The letter made some explanation as to why the information was elicited, and asked for the person's cooperation in answering the included questions.

Table V

DISTRIBUTION OF 120 CASES ACCORDING TO SOCIAL SERVICE CONTACT

Type of Service	Number	Per Cent
No service	90	75
Incidental service	18	15
Case work treatment	12	10
Total	120	100

The questions in the form letter were directed toward formulating some specific reasons why patients had discontinued coming to the clinic. Was there something in the clinic setting itself which was disturbing, such as waiting for appointments, changing doctors, or not having needs met by the social service staff? If patients terminated treatment did they go elsewhere? Of so, where to, to a private doctor, a psychiatrist, or a clinic? How beneficial in the patient's estimation was the changed treatment? If patients had terminated treatment because, in their own estimation, they were no longer in need of it, could this be measured in terms of their adjustment at home, at school, at work, or among their friends?

Forty-five persons or 38 per cent of those receiving letters replied. Thirty-eight included explanatory notes, the majority of which expressed their saitsfaction with the clinic, its treatment and its personnel. A few included various reasons for discontinuing treatment. Five felt that traveling to the clinic had become a burden. One of these, a mother of two young children, felt that she had benefited greatly by treatment and expressed the wish to return, but she could no longer make arrangements for the care of her children during her absence. Two persons felt that coming to a psychiatric clinic had been a mistake. One young man had been referred by his physician and diagnosed as presenting paranoid trends; he wrote denying that his was a psychiatric problem. He has returned to work and feels that he is entirely well now, and adds that there was never anything wrong with him. The other patient was a child of eight whose mother had been referred to the clinic by the school. This child had presented many behavior problems at home, at school, and with his playmates. The mother wrote that she could not accept the fact that the child's behavior had any psychiatric implications; she felt that he had been reacting to a bad school situation. She had transferred the child to another school and felt that his adjustment had been improved not only in school but also at home and with his playmates. This mother added that she had been a

patient for a short time in a psychiatric hospital, had been quite disturbed but was well again, and wished to erase the entire experience from her mind.

Few persons answered all the questions. It is the writer's interpretation that the patients questioned the second query, "How long did you feel better?" It seems a difficult question to interpret in the framework of the patient's experience because the duration of mental and emotional illnesses is so ill defined.

Most answers were specifically "Yes" or "No". Several persons, however, did answer "Uncertain". This may be significant in that the patient questions whether he is entirely well or not, or hesitates to commit himself to a direct reply in answering such a question as "Would you return to the clinic if urged?". One of the patients who expressed doubt was a young woman who had terminated treatment because she was not certain that anyone could help her. Inasmuch as she answered several questions "Uncertain" and wrote a further note explaining her hesitancy to accept the fact that she could be helped, the writer felt that her answers could be in part at least due to her illness, and thus were not a real evaluation of the clinic service or staff.

Chapter III

A Study of Forty-five Cases Who Replied To the Questionnaire

The forty-five cases replying to the form letter were classified according to age and sex, diagnostic distribution and source of referral. Then a comparison was made of the percentages between the diagnostic distribution of the 120 cases selected for the study and those of the forty-five cases which had replied to the form letter. This was done in an effort to determine whether this sample of forty-five cases was characteristic of the whole. A comparison of these figures reveals that the sample is fairly characteristic. The percentage of children was lower in the sample of forty-five cases but no explanation can be given for this. The greatest discrepancy in the comparison of these two diagnostic percentages is revealed in the patients in the depression category. Several possible answers can be formulated; it well may be that this group responded well to treatment, that their symptoms were reduced, and that they therefore felt more friendly toward the clinic and more responsive to the form letter.

The writer can only surmise why some patients responded to the letter and others did not. A reasonable assumption is that those persons most interested in their problem responded to the greatest extent. Those who had the friend-

liest feelings to the clinic were prone to respond. It is an equally plausible assumption that, feeling relieved of their symptoms, the clinic and treatment have become fused and are such a tenuous part of everyday living for these patients as to be disregarded.

Distribution of the forty-five cases according to age and sex indicates that there were five children thirteen years of age and under, two boys and three girls; and eleven adolescents between the ages of fourteen and eighteen years, four boys and seven girls. The adult group totaled twenty-nine persons; of this number seven were males and twenty-two were females.

A diagnostic distribution of these cases shows that three or 7 per cent of the group were children who had failed to adjust in school; and an equal number were children who presented multiple neurotic disorders. Six persons diagnosed as anxiety formed 13 per cent of the group. Four persons with epilepsy or 9 per cent responded to the letter; of these, two felt that their symptoms had been controlled , and the other two had transferred to private physicians. Of the two who had transferred, one explained that he had come to the clinic during the time that his physician was in army service. This patient further stated that he had great fear of traveling, but that he had been pleased with his experience in the clinic. There were three persons or 7 per

cent showing schizophrenic trends, who responded. The largest single group were the persons diagnosed as suffering from depression; this included eleven persons or 24 per cent of the total of forty-five cases. The mixed types of psychoneuroses representing nine persons, formed 20 per cent of the group; and those persons exhibiting psychopathic trends numbered six, or 13 per cent of the total.

Table VI

COMPARISON OF PERCENTAGES OF DIAGNOSTIC DISTRIBUTION

Diagnosis	Per Cent 120 Cases	Per Cent 45 Cases
Failure in school adjustment	11	7
Multiple neurotic traits	7	7
Anxiety	19	13
Depression	20	24
Epilepsy	9	9
Schizophrenic trends	6	7
Psychoneurosis, mixed types	20	20
Psychopathic trends	8	13
Total	100	100

A study of the distribution of the forty-five cases according to the source of referral indicated that fourteen persons or 31 per cent were referred by hospitals; and that ten or 22 per cent were referred by physicians. Nine or twenty per cent came of their own accord, or at the suggestion of some member of the family. Five patients or 11 per cent were referred by the school, four patients or 9 per cent

by family agencies, and three or 7 per cent by other social agencies.

Outstanding in the reply to the first question in the form letter, "Did you receive any help from your visits to the clinic?", is the fact that all patients answered the question, and that 91 per cent felt that they had benefitted by treatment. Of the two who felt that they had not been helped, one was the eight year old child previously mentioned. The other was an eighteen year old girl with anxiety neurosis who transferred to another clinic and is now being seen by the social worker; she does not feel that this second clinic has been of much help either.

The second question, "How long did you feel better?", has been discussed elsewhere in the study. The four persons answering the question gave one month, six months, one year, and two years respectively, as the period of time covering the beneficial results of their treatment.

All patients answered the question, "Do you feel you are entirely well now?" Fifty-one per cent of the group felt that they were, and forty-nine per cent felt that they were not entirely well. Thirty-one persons, or 67 per cent of the group, indicated that they would return if they felt sick again; eight, or 18 per cent, stated that they would not return; and two were uncertain. Four did not answer the question.

Few persons answered the question, "What didn't you like about the clinic?". One young man, after noting the fact that he objected to waiting for the doctor and to changes in doctors, added that he objected to these things but that they would not deter him from returning should his symptoms reappear. One person did feel that these things influenced her so that it was necessary to go to a private psychiatrist. Five persons made special mention of their warm feelings for the doctor. Of two persons answering the question by needs not met by the social worker, one stated that she would have liked this service and felt that she could use it, but she had had no contact with a social worker. The other person had been seeing a social worker regularly but she felt that she now sees greater possibilities in the service which she had not previously realized.

Thirty-one persons or 69 per cent stated that they would have returned had they been urged to do so. All but one patient in this group felt that they had been helped to improve by coming to the clinic. Sixteen of the thirty-one patients signifying their willingness to return answered "Yes" to the question, "Do you feel you are entirely well now?". Fifteen answered "No" to the same question. This poses an interesting problem, since it is logically at variance to say that one is well but would return to the clinic if urged. This can be countered with another; name-

ly, that had some form of follow-up been instituted shortly after treatment had been discontinued these patients might have been maintained in treatment. Five of this number had been carried by the social service department for case work treatment. It is customary for the social worker to write, telephone, or only occasionally to visit the patient who has been seen regularly and suddenly stops coming. Therefore it would seem that 11 per cent of the group who signified their willingness to return had been asked to do so but had not responded. One wonders then whether something in the nature of the illness or in the treatment, which was not clear to the patient and not too well defined by the psychiatrist or the social worker, is a factor in the termination of treatment by patients who in the estimation of the psychiatrist are not symptom free.

Further analysis of the data shows that four patients had transferred to family physicians for care. Two of these were epileptics, one a boy of eight and one an adult previously mentioned. Two patients sought private psychiatric care, one a woman who expressed a great deal of negative feeling about the clinic and its personnel, and another a woman who felt that temporary hospitalization would give her the rest and change she needed. This she obtained through private resources, and she wrote that she was very much improved but is considering returning to the clinic for periodic

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consultation, since she is financially unable to continue private psychiatric care. Of the two patients who went to other clinics, one is a young woman previously mentioned, and the other an adolescent boy who gave no explanation as to the kind of clinic he was attending or what treatment he was receiving. He stated that he is now working and the distance and choice of clinic time do not fit into his present schedule. This boy had been referred by the court for minor charges, and is now making a good adjustment. He felt that he had been helped by the clinic and would have returned had he been urged to do so.

Four of the patients who had gone elsewhere for treatment are still under care, two epileptics under the care of family physicians, one woman under the care of a clinic, and one woman under private psychiatric care. Six signified that they had been helped by treatment elsewhere; two felt that they had not. Forty-one persons or 91 per cent stated that they were getting along better at home, two felt that there had been no change, and two were uncertain. These figures parallel the answers to the first question, and strengthen the value of psychiatric treatment in terms of better social adjustment. This is equally true of those who felt they were getting along better with their friends. A somewhat smaller number, thirty-six persons or 80 per cent, felt that they were better adjusted at work, whether it was

consultation, since she is financially unable to continue private psychiatric care. Of the two patients who went to other clinics, one is a young women previously mentioned, and the other an adolescent boy who gave no explanation as to the kind of clinic he was attending or what treatment he was receiving. He stated that he is now working and the distance and choice of clinic time do not fit into his present schedule. This boy had been referred by the court for minor charges, and is now making a good adjustment. He felt that he had been helped by the clinic and would have returned had he been urged to do so.

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Table VII

ANALYSIS OF 45 REPLIES TO THE FORM LETTER SENT OUT

Question	Yes	No	Uncertain	No Ans.	Total
1. Did you receive any help from your visits to the clinic?	41	2	2		45
2. How long did you feel better?*					4
3. Do you feel you are entirely well now?	23	22			45
4. Would you return if you felt sick again?	31	8	2	4	45
5. If not, what didn't you like about the clinic?					
Your doctor?	2				2
Waiting a long time for the doctor?	4				4
Changing from one doctor to another?	4				4
Things the doctor said to you?	1				1
Needs not met by the social worker?	2				2
6. Would you have returned if you had been urged?	31	4	2	8	45
7. Did you go elsewhere for the same trouble?	8	37			45
8. Where?					
Family doctor?	4				4
Psychiatrist?	2				2
Clinic?	2				2
9. Are you still under their treatment?	4	4			8
10. Do you think they helped you?	6	2			8
11. Do you think you are getting along better					
at home?	41	2	2		45
with friends?	40	3	2		45
at work?	36	3	6		45

* Four persons answered the question by one month, six months, one year, and two years, respectively.

in private employment or in the household tasks of the homemaker. Three persons felt that there was no improvement, and six were uncertain.

The forty-five cases were further studied in an effort to determine what diagnostic groups would return to the clinic if they felt sick again. In the largest single group, diagnosed depression, nine of the eleven persons stated that they would return; one would not, and one was uncertain. Of the next largest group, those with mixed types of psychoneuroses, eight would return and one would not. Two persons with epilepsy stated that they would return, and two that they would not. The latter two are those who are receiving care from private physicians.

In the group diagnosed as psychopathic trends, which included the most serious mental illnesses, two persons answered that they would return if they felt sick again, and two replied that they would not; both of these latter were patients presenting paranoid trends. The two who did not answer the question stated that they were entirely well, and it is possible that this question seemed irrelevant to them. (See Table VIII, page 30)

Table VIII

DIAGNOSTIC DISTRIBUTION OF 45 CASES ANSWERING THE QUESTION, "WOULD YOU RETURN IF YOU FELT SICK AGAIN?"

Diagnosis	Yes	No	No Answer	Uncertain
1. Failure to adjust in school	2	1		
2. Multiple neurotic traits	2	1		
3. Anxiety	3	1	1	1
4. Epilepsy	2	2		
5. Schizophrenic trends	3			
6. Depression	9		1	1
7. Psychoneurosis - mixed types	8	1		
8. Psychopathic trends	2	2	2	

Table IX

DIAGNOSTIC DISTRIBUTION OF RESPONSE OF 45 CASES TO THE QUESTION, "DID YOU RECEIVE ANY HELP FROM YOUR VISITS TO THE CLINIC?"

Diagnosis	Yes	No	No Answer	Uncertain
1. Failure in school adjustment	2	1		
2. Multiple neurotic traits	3			
3. Anxiety	4			2
4. Epilepsy	4			
5. Schizophrenic trends	3			
6. Depression	11			
7. Psychoneurosis - mixed types	9			
8. Psychopathic trends	5	1		

Table X

DIAGNOSTIC DISTRIBUTION OF 45 CASES ANSWERING THE QUESTION, "DO YOU FEEL ENTIRELY WELL NOW?"

Diagnosis	Yes	No	No Answer	Uncertain
1. Failure to adjust in school	3			
2. Multiple neurotic traits		3		
3. Anxiety	1	5		
4. Epilepsy	2	1	1	
5. Schizophrenic trends	2	1		
6. Depression	7	4		
7. Psychoneurosis - mixed types	5	4		
8. Psychopathic trends	4	2		

Table XI

DIAGNOSTIC DISTRIBUTION OF 45 CASES ANSWERING THE QUESTION, "WOULD YOU HAVE RETURNED HAD YOU BEEN URGED?"

Diagnosis	Yes	No	No Answer	Uncertain
1. Failure to adjust in school	2		1	
2. Multiple neurotic traits	2	1		
3. Anxiety	5		1	
4. Epilepsy	3	1		
5. Schizophrenic trends	3			
6. Depression	7		3	1
7. Psychoneurosis - mixed types	7	1	1	
8. Psychopathic trends	3	1	1	1

Table X

DISAGREEMENT DISTRIBUTION OF 46 CASES ANSWERING
THE QUESTION "DID YOUR PUPIL ATTEMPT
REAL HARM?"

Diagnosis	Yes	No	No Answer	Uncertain
1. Failure to adjust in school	3			
2. Multiple neurotic trends		3		
3. Anxiety	1	3		
4. Epilepsy	2	1	1	
5. Sublimpulsive trends	3	1		
6. Depression	7	4		
7. Psychoneurosis - mixed types	3			
8. Psychopathic trends	4	3		

Table XI

DISAGREEMENT DISTRIBUTION OF 46 CASES ANSWERING
THE QUESTION, "DID YOU FEEL PUPIL'S BEHAVIOR
WAS YOUR FAULT IN PART?"

Diagnosis	Yes	No	No Answer	Uncertain
1. Failure to adjust in school	2	3		
2. Multiple neurotic traits	2	1		
3. Anxiety	0	1		
4. Epilepsy	2	1		
5. Sublimpulsive trends	0			
6. Depression	7	0		1
7. Psychoneurosis - mixed types	1	1		
8. Psychopathic trends	2	1	1	1

Chapter IV

Summaries of Two Case Histories

M. was a fifteen year old child in the ninth grade at school. She was referred to the clinic by a social worker from a general hospital. The child had been brought to the medical clinic by her mother because she had been persistently knocking her head against the wall, and several times had sustained injury. The history taken at this time had revealed that M. did not adjust either at school or at home. She was frequently a truant from school, and expressed the wish to go to work. There was some question in the mind of the mother as to the child's ability to learn. The case at this point was referred to the Southard Clinic.

The social history taken at the clinic showed that M. had not been an outstanding problem until recently. She was reported by her mother to be restless in her sleep and to have disturbing dreams. She frequently knocked her head so violently in her sleep that the family were concerned. The school records showed that M. was slow in her work, and retarded three years. She was surly with the teachers, was interested in boys, and was seen to be with them a great deal on the playgrounds. The psychological examination, New Stanford Binet, indicated average intelligence.

M. was seen regularly at the clinic by the psychiatrist at weekly intervals for fourteen months. The psychia-

trist felt that M. had a great deal of deprivation in her home environment and that she was struggling to adjust to it. In the course of her psychiatric treatment M. became more friendly and outgoing. She eventually left school, took a job, and now both M. and her mother feel that she has shown marked improvement at home and in all other relationships. M. discontinued coming to the clinic because she felt well and because her work interfered with clinic appointments.

Mrs. G. is a forty-five year old widow. She is attractive looking and a meticulously groomed person. Mrs. G. had been a patient at a general hospital for one month because of dizzy spells. Little improvement resulted and she was referred to the Southard Clinic.

Mrs. G. stated that she had worked for years, supporting herself and her son, now fifteen years old. Her increasing nervousness was interfering with her secretarial work, and with her relationship with her son. She is extremely rigid and demanding with him.

Mrs. G.'s parents brought her home to live with them when her illness became incapacitating. Of her parents, Mrs. G. stated that they were very strict in her upbringing. For this reason she felt superior to the girls with whom she grew up. She finished high school, completed a business college course, and got a good job as a private secretary.

She felt that she did not have to marry as did other girls. She was always an orderly, self-sufficient person, and had no patience with others less meticulous than herself. She has always had fears of people and has been constantly apprehensive of danger. Her symptoms of dizziness have increased in the past few months so that she has been unable to work or leave the house for fear of fainting and sustaining injury. The patient at this time was diagnosed as an obsessional neurotic with conversion symptoms.

Mrs. G. saw the psychiatrist weekly for eleven months, and the social worker for five months at weekly intervals. She was referred to the social service department for possible help in job planning and for help with the difficult home situation. Mrs. G. was finding it hard to live with her parents again, and yet was apparently dependent on her seventy-three year old mother for actual physical care at times. The home situationwas more acute because Mrs. G.'s father had carcinoma. With treatment at the clinic Mrs. G. improved to the point where she could return to work, and take up housekeeping apart from her parents. She still had some symptoms but discontinued coming to the clinic.

In response to the form letter Mrs. G. stated that she had got some help from the clinic but added that the medication prescribed by the psychiatrist had been of no value. She objected to changing doctors, and to waiting for

appointments, and eventually went to a private physician and was treated by him for a few months. She had not seen the physician for one year but continues to take the medication prescribed by him. She felt that she had been helped by him. Mrs. G. was forced to resign her secretarial job and is now doing clerical work. She added in her letter that she would have returned to the clinic had she been urged.

Chapter V

Conclusion

In this study an attempt was made to determine the results of psychiatric treatment in an outpatient clinic, to gain some understanding as to why patients who, in the estimation of the psychiatrist should be under treatment, terminate treatment of their own volition, and finally to explore the interests of patients in follow-up.

The number of cases used in the study does not permit one to make definite conclusions. This number can only indicate trends. However the study does illustrate some pertinent facts. Ninety-one per cent or forty-one of the patients felt that they had been helped by treatment in the clinic. Fifty-one per cent of the group indicated that they would return if their symptoms reappeared. These people did get help, had a good relationship to the clinic, and would seek the clinic again if they needed help.

One of the basic tenets of psychiatric theory and practice is that the patient must come to treatment of his own volition and that his interest in continuing is an inherent part of treatment. Since these patients did terminate treatment, it is reasonable to assume that they were not interested in complete recovery or in continued treatment. However a large part of the group, sixty-seven per cent, indicated that they would have returned had they been

Page 7

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One of the basic tenets of psychiatric theory and practice is that the patient must come to treatment of his own volition and that his interest in continuing is an important part of treatment. Since these patients did terminate treatment, it is reasonable to assume that they were not interested in complete recovery or in continued treatment. However a large part of the group, sixty-seven per cent, indicated that they would have returned had they been

urged to do so. Operating in this is a positive relationship with the clinic which, had some initiative been taken by the clinic, would have meant continued treatment of the patient. Furthermore, discontinuance of treatment does not necessarily indicate the patient's lack of interest in continuous treatment, since sixty-seven per cent indicated that they had had a good relationship and would return. The question therefore is raised, if these factors exist, whether the need for continued treatment was interpreted by the clinic, or the patient was given an understanding of the need for continued treatment. This also raises the question as to whether the patient comes to the clinic only when he is uncomfortable with his symptoms. When the symptom is relieved the patient will not wish to return unless there is a specific interpretation by the clinic that being symptom free does not necessarily mean that the client has an understanding of his illness or his treatment.

The study further points up the fact that administrative factors, inherent in the clinic set-up, such as waiting for appointments, changing doctors, or needs not met by the social worker, matter little in terms of whether the patient continues treatment. The majority of persons answering these questions indicated that some form of a positive relationship had been maintained despite these factors.

One of the interesting points brought out by the study

is the fact thst such a small percentage of patients went elsewhere for treatment. This may well be answered by their response to the first question, indicating that amelioration of symptoms was the patient's understanding of the extent and need of treatment. Other factors, however, cannot be disregarded. The cost of private psychiatric care, the pressure of work of all psychiatric clinics, and finally the limited number of hospitals giving this service, would be discouraging to patients wishing to make a change.

This study strengthened the belief that the patient's adjustment at home, at school, at work, or in the community, improves as his symptoms are alleviated. This may play an important role in the termination of treatment.

In analyzing the diagnostic distribution of the forty-five cases studied, the writer finds that the majority, seventy-five per cent, fall in the diagnostic categories which best lend themselves to treatment, twelve per cent children, thirteen per cent anxiety states, forty-four per cent depressions, and six per cent schizophrenic trends. Therefore in the interest of prevention or recurrence, which is costly to the patient and to the community, the writer raises the question of what percentage of the total group could have been helped more substantially if some form of follow-up had been instituted. Based on the findings of this study, it seems valid to recommend that some form of

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follow-up be instituted after patients have discontinued treatment of their own volition.

Approved

Richard K. Conant

Richard K. Conant, Dean

Schedule

1. Age
2. Sex
3. Source of referral
4. Diagnosis
5. Social service contact
6. Questions on form letter (see pages 41-42)

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DIRECTOR

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CHARLES R. ATWELL
CHIEF PSYCHOLOGIST

ESTHER C. COOK
CHIEF SOCIAL WORKER

Doctors, social workers and other members of the clinic staff constantly wonder if they are giving patients the kind of help the patients want. In order to find out we make studies from time to time, studies which include information from former patients. We feel that this will be of help to others since it may lead us to improve our methods. As a former patient we hope you will be willing to answer the following questions.

Did you recieve any help from your visits to the clinic?
How long did you feel better?
Do you feel that you are entirely well now?
Would you come back if you felt sick again?
If not what didn't you like about the clinic-check below
Your doctor?
Waiting a long time for the doctor?
Changing from one doctor to another?
Things the doctor said to you?
Needs not met by the social worker?
Other reasons:

Would you have returned if you had been urged to come back?
Did you go elsewhere for the same trouble?
If so to whom: Family physician? Psychiatrist? Clinic?
Do you think they helped you?
In what ways?

Are you still under their treatment?

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Do you think you are getting along better at:

Home? with you friends? at work? at school?

If you are working, is the job the same one you had six months ago?

If you have changed jobs what kind of work are you doing now?

Thank you very much for the trouble you have taken in giving us this information.

Sincerely Yours,

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